Riley County Health Department
2030 Tecumseh Rd
Manhattan, Kansas 66502
Phone: 785-776-4779
Fax: 785-565-6565
www.rileycountyks.gov/flu

2018-2019 Influenza Consent Form

DEMOGRAPHICS

Patient's First Name: **Middle Name:** **Last Name:** **Maiden Name/Alias:**

Birth Date: **Age:** **Phone Number:** **Social Security Number:** **Primary Language:**

Ethnicity: Hispanic ____Yes ____No

Gender ____Male ____Female

Race:
___ Asian/Pacific Islander/Other ___ Caucasian or White
___ Black or African American ___ Hawaiian
___ Native American/Alaska Native ___ Unknown or Other_____

Doctor:

Mailing Address: **Apt #:** **City:** **State:** **County:** **Zip Code:**

BILLING & HIPAA

Yes_____ No_____ immunizations are covered by my health insurance? If **NO** : read carefully - IN ORDER TO COMPLY WITH STATE REGULATION WE ARE UNABLE TO USE (VFC) INJECTIONS UNLESS WE HAVE A WRITTEN STATEMENT FROM YOUR INSURANCE COMPANY STATING IMMUNIZATIONS ARE NOT COVERED. IF WE DO NOT HAVE A WRITTEN STATEMENT PRIOR TO INJECTION THE PATIENT WILL BE RESPONSIBLE FOR ANY PORTION THAT INSURANCE WILL NOT COVER.

Primary Insurance Carrier

Insurance Co. Name _____ ID#:_____ Group#_____

Policy Holder (Name): _____ Policy Holder's Birthdate: __/__/____

Patient's relationship to policy holder (child, spouse, self) _____

Secondary Insurance Carrier

Insurance Co. Name _____ ID#:_____ Group#_____

Policy Holder (Name): _____ Policy Holder's Birthdate: __/__/____ Patients relationship to policy holder (child, spouse, self) _____

By my signature below, I authorize the Riley County Health Department to bill any of the medical payers as indicated above and provide necessary information to process claims. I authorize payment of medical benefits to the Riley County Health Department for services rendered and I understand I will be responsible for payment of charged deemed "uncovered" by my health insurance.

All records of services rendered are considered confidential. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Riley County Health Department and payment is not made by KanCare or your Health Insurance, you may be responsible for the charges. You may also be responsible for charges. If you fail to inform the Health Department of Insurance coverage in a timely manner. I have read the information above, understands the information and agree with my signature below. I also certify that the information provided on this page is true and correct to the best of my knowledge. I acknowledge that I was offered a copy of the RCHD Privacy Policy dated 9-2013.

SIGNATURE _____ **DATE** _____

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Are you sick or experiencing a high fever?	Yes No
2. Do you have allergies to medications, food, a vaccine component, or latex? List:	Yes No
3. Have you ever had a serious reaction after receiving a vaccination? Please explain:	Yes No
4. Have you ever had Guillain-Barré syndrome? (autoimmune disorder in which the immune system attacks nerve cells)	Yes No
5. Are you pregnant or planning on become pregnant in the next year?	Yes No
6. Are you 19 years of age or older with one or more of the following medical conditions; pregnant, asthma, chronic lung disease (COPD, cystic fibrosis), chronic heart disease (congestive heart failure, coronary artery disease), diabetic, obese, or have a weakened immune system (HIV, cancer, chronic steroids), or have another chronic (on going) medical condition not listed? **If so, please circle or list here…**	Yes No <19 years of age

VACCINE CONSENT

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above. **☒ Influenza**

X_____ **Date:**_____

Signature of Client or Parent/Guardian

PATIENT ELIGIBILITY (FOR CLINIC AND/OR OFFICE USE ONLY)

Public	**T19-MED**	**Manufacturer:**	**90662**	FLU HIGH DOSE (65 yrs +)
Public	**No Health Insurance ≤ 18**	**Lot Number:**	**90686** P/T21/T19	Fluarix or FluLaval (6 mo +)
Public	**Nat Am/Al Nat**	**Expiration Date:**	**90686P (Public)**	Fluarix or FluLaval (6 mo +)
Public	**Underinsured**	**INJECTION SITE:**	**90682**	FluBlok (RIV4) (18 yrs +)
Public	**T21-CHIP**	**Left / Right** **Deltoid / Vastus Lateralus**		
Private	**Fully Insured**			
Private	**No health insurance ≥ 19**			
			90471	1st Injection
	FREE FLU – NO CHARGE	**VACCINE ADMINISTRATOR:** **Date:**	**G0008**	Medicare Flu Injection